

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10311

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission) a. STATE <b>506 Cedarcroft Road</b> <b>BALTIMORE</b> MD <b>12</b> <b>30-4</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> OCEAN CITY <b>59425</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> MD <b>30-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ocean Park Motel Ocean City, Maryland</b>		d. STREET ADDRESS <b>506 Cedarcroft Road</b>	
3. NAME OF DECEASED (Type or print) <b>ROSE</b> First <b>May</b> Middle <b>BARLOW</b> Last		4. DATE OF DEATH <b>7/20</b> Month <b>1967</b> Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/07</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BAIT.</b>	
11. BIRTHPLACE (State or foreign country) <b>BAIT.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. Wm. Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Laura Brown Brooks</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-16-1510</b>	
17. INFORMANT <b>Husband</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR Collapse</b> <b>H201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Anterior &amp; Posterior Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NO</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>J. Donald Capra</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>J. DONALD CAPRA MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/24/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Eugenia K. Seitz 5209 York Road</b> <b>Seitz Funeral Home Balto. Md. 21212</b>		25a. REC'D BY REGISTRAR <b>JUL 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22. DATE SIGNED <b>July 21 1967</b>	

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10312

## CERTIFICATE OF DEATH

10312

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>304</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY in 1b <u>7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>16th St. + Philadelphia Ave.</u>		d. STREET ADDRESS <u>3623 Roberts Place</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE JOHN BENZING</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>AUG 28 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BETH STEEL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	9. AGE (In years last birthday) <u>66</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>GEORGE BENZING</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE FELHBAUM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-07-2011</u>	
17. INFORMANT <u>ELIZABETH STIEMLY</u>		Address <u>8431 RAVENHUGH RD. BALT. 22, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio. Pulm. arrest</u> DUE TO (b) <u>Prob. Myocardial Infarct</u> DUE TO (c) <u>Arteriosclerotic Cardio-Vascular Dis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>10 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>TERMINAL</u> to <u>1-17</u> , 19 <u>67</u> , and that death occurred <u>1:30 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Philip P. Brous</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP D. BROUS</u>		22d. ADDRESS <u>1601 PHILADELPHIA AVE. Ocean City</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>7401 GERMAN HILL RD. BA. CO., MD.</u>
24. FUNERAL DIRECTOR <u>Charles S. Jule</u>		25a. REC'D BY REGISTRAR <u>JUL 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jule</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

51912

1997 12 30

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10313

CERTIFICATE OF DEATH

10313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>807-2nd St.</u>		d. STREET ADDRESS <u>807-2nd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Henry</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11, 1888</u>
9. AGE (In years - last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Georgie Ella ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>240-05-7720</u>	
17. INFORMANT <u>Lottie Baquell</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure.</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Arterial Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3-4 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>63</u> , to <u>7/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Neville A. Baron</u> M.D.		22b. DATE SIGNED <u>7/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>		22d. ADDRESS <u>Pocomoke, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tindley Chapel Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Sauer</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# FOR STATE HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #6 Film #G391 8/2/67 pb MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10314

10314

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Chincoteague</u> b. COUNTY <u>Maryland</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>			c. LENGTH OF STAY IN 1b <u>2 months</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1001 Phila. Ave. Ocean City, Md</u>			d. STREET ADDRESS <u>103 Smith Street</u>		
3. NAME OF DECEASED (Type or print) <u>Clarence W. Carpenter</u>			4. DATE OF DEATH <u>July 26</u> 19 <u>67</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8</u> 18 <u>99</u>	9. AGE (In years last birthday) <u>68</u> yrs	10. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISHERMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Chincoteague</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Carpenter</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Williams</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>?</u>		
17. INFORMANT <u>Wife</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>None</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)		
20c. TIME OF INJURY Month, Day, Year <u>8:31</u> a.m. <u>1967</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>J. Donald Capra</u> EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		
22. DATE SIGNED <u>7/26/67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-30-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Daisy Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Chincoteague, Virginia</u>		23e. REC'D BY REGISTRAR DATE <u>JUL 31 1967</u>			
23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>					
24. FUNERAL DIRECTOR <u>Salyer Funeral Home, Chincoteague, Virginia</u>					

1901

I have been thinking of you  
very much lately and wondering  
how you are getting on. I hope  
you are well and happy. I am  
still the same old me, but  
I am getting on as well as I can.

I am sure you are doing  
very well. I am sure you are  
happy and content. I am sure  
you are doing everything  
just as you should. I am sure  
you are doing everything  
just as you should.

I am sure you are doing  
everything just as you should.  
I am sure you are doing  
everything just as you should.  
I am sure you are doing  
everything just as you should.

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FOR STATE HEALTH DEPT.

10315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10315

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dean City</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Hgts. - Md</u>				d. STREET ADDRESS <u>7322 District Pkwy</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hamilton Hotel</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellen Olli Castle</u>				4. DATE OF DEATH <u>July 26 1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11, 1918</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>usgout</u>		11. BIRTHPLACE (State or foreign country) <u>Palace Colorado</u>	
13. FATHER'S NAME <u>HERMAN Olli</u>				14. MOTHER'S MARDEN NAME <u>Mildred Olli</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Eugene Castle (Husband)</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3220</u> DUE TO <u>Ethylism, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURE</u> (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>F.J. Townsends, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F.J. Townsends, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED <u>July 26, 1967</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND, PRINCE GEORGES, Md.</u>	
24. FUNERAL DIRECTOR <u>ROBERT E. WILHELM FUNERAL HOME</u> <u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10316

10316

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>ACCOMACK</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>OCEAN CITY</b>				c. LENGTH OF STAY IN 1b <b>3 WKS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KELLER</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>OCEAN, FOOT OF 7TH AVE.</b>				d. STREET ADDRESS <b>PO BOX: KELLER, VA</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RONNIE</b> Middle <b>CONQUEST</b> Last <b>CONQUEST</b>				4. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>1967</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1952</b>		9. AGE (In years, months, days, hours, minutes) <b>14 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of workable life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>#</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE KELLAM HATTIE</b>				14. MOTHER'S MAIDEN NAME <b>HATTIE CONQUEST</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>228-72-6950</b>		17. INFORMANT <b>CALVIN SMITH</b>		Address <b>WACHAPREAGUE VIRGINIA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1298 ASPHYXIAATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>DROWNING PULMONARY EDEMA</b> MINUTES (c) <b>DROWNING</b> MINUTES							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>FELL OFF SURFBOARD UNABLE TO SWIM</b>					
20c. TIME OF INJURY Month, Day, Year <b>10:15 PM 7/3/67</b>		20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.) <b>BEACH</b>		20f. (City or town), (County), (State) <b>OCEAN CITY, WORCESTER, MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.F. KAPPELHORN</b>		EXAMINER'S NAME (Type) <b>R.F. KAPPELHORN</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>7/3/67</b>	
23a. MANNER OF CREMATION, Burial		23b. DATE THEREOF <b>7-08-67</b>		23. NAME OF CEMETERY OR CREMATORY <b>Red Hill</b>		23d. LOCATION (City or Town), (County), (State) <b>Keller, Va.</b>	
24. FUNERAL DIRECTOR <b>G.C. Humble</b>		ADDRESS <b>Accomack, Va.</b>		25a. REC'D BY REGISTRAR <b>JUL 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10317

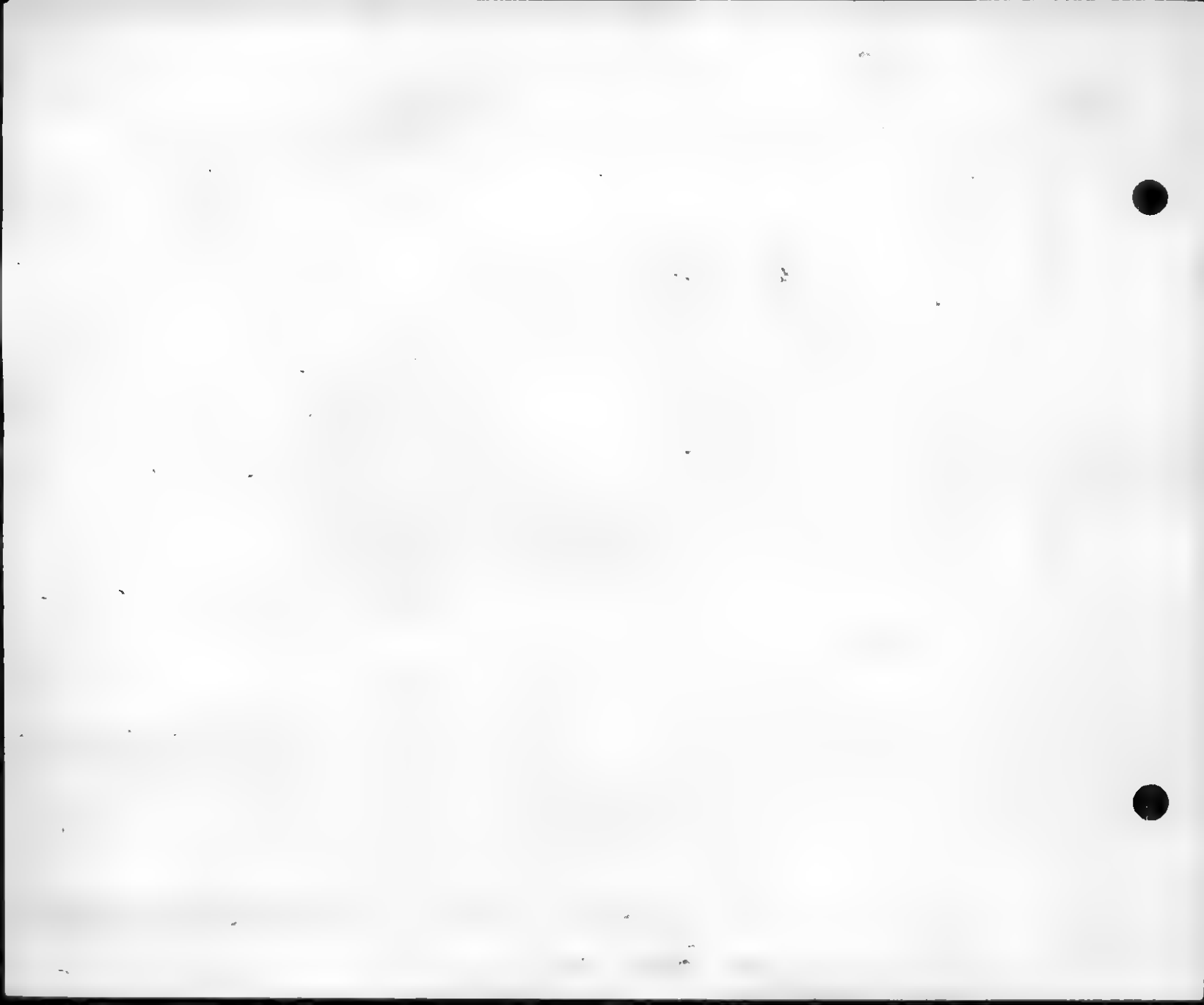
10317

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, OCEAN CITY</b>				c. LENGTH OF STAY N 16 <b>8 HRS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FISHING BOAT</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 22</b>			
f. STREET ADDRESS <b>1404 STENGLE AVIE</b>				g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>UPSHAW JAMES CUSTIS</b>				4. DATE OF DEATH Month <b>7</b> Day <b>1</b> Year <b>1967</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6/22/06</b>	
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>		11. BIRTH-PLACE (State or foreign country) <b>Pocomoke, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>JANITORIAL</b>			
13. FATHER'S NAME <b>JAMES M. CUSTIS</b>				14. MOTHER'S M.A.DEN NAME <b>MCCREARY JUSTIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>219-06-4914</b>		17. INFORMANT <b>JOS. A. THOMAS, 8428 KAVANAGH ST BALT, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b> <b>4-0-1</b> DUE TO (b) <b>MYOCARDIAL INFARCT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>ARTERIO SCLEROTIC CARDIOVASC. DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>YEARS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SEASICKNESS</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)			
20c. TIME OF INJURY Month, Day, Year <b>11</b> Hour <b>4</b> m <b>1</b> p <b>1967</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <b>FISHING BOAT</b>	
20f. (City or town) (County) (State) <b>OCEAN CITY WORCESTER MD</b>				20g. (City or town) (County) (State) <b>OCEAN CITY WORCESTER MD</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.F. KAPTELOWITZ</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.F. KAPTELOWITZ</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street city town or county)			
23a. BURIAL, CREMATION, or other disposition <b>BURIAL</b>		23b. DATE THEREOF <b>7-4-1967</b>		23c. NAME OF CEMETERY <b>NELSON CEMETERY</b>		23d. LOCATION (City or town) (County) (State) <b>ACCOMACK COUNTY VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>Robert H. Watson Pocomoke City, MD</b>				25a. REC'D BY REG STRA <b>JUL 5 1967</b>			
25b. REAFFIRMED BY JUDGE <b>7/1/67</b>							



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

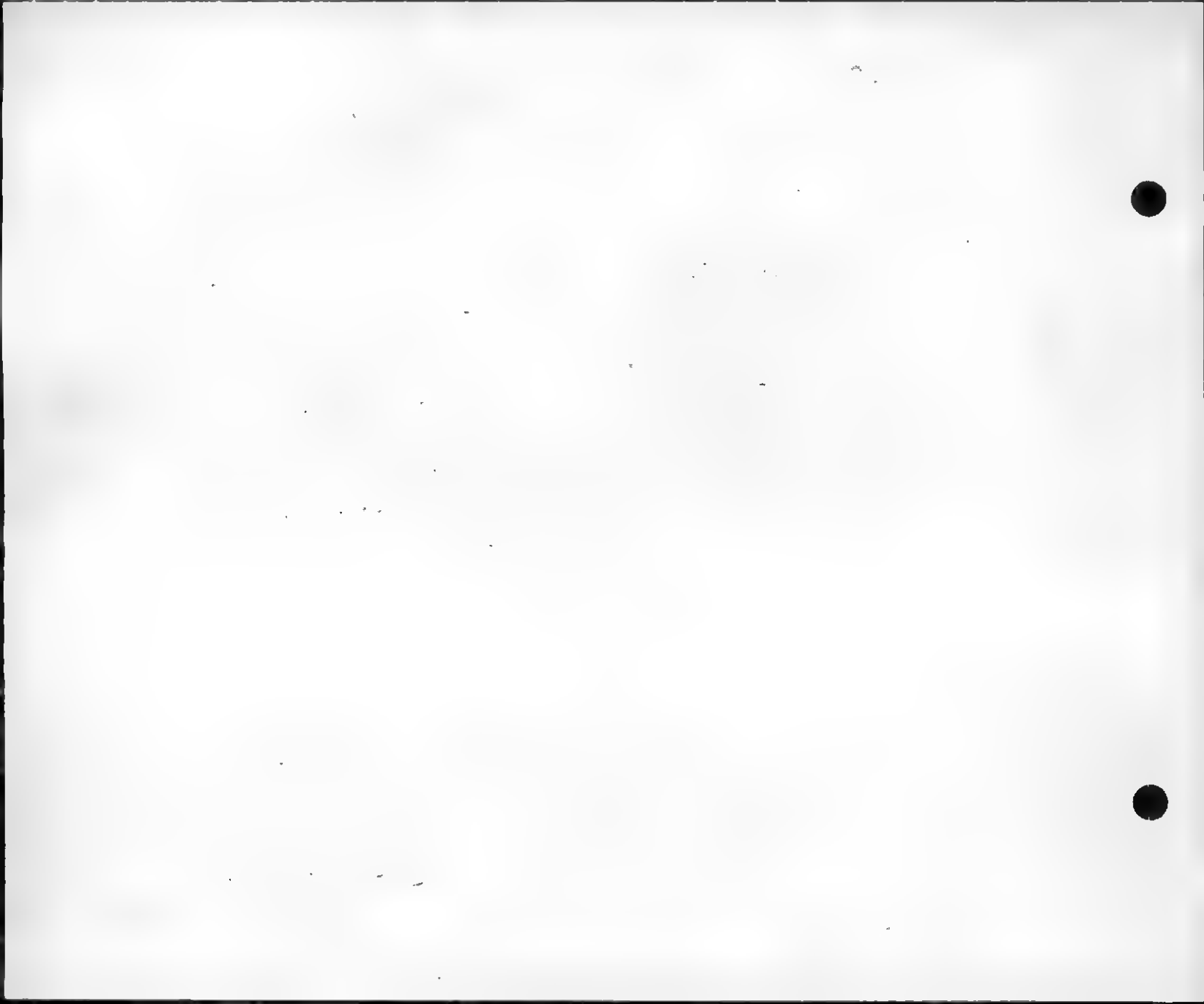
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10316

10318

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>WOR</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Whaleyville</u>		c LENGTH OF STAY in 1b <u>35 years</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Whaleyville</u>		d STREET ADDRESS <u>RI Box 246</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RI Box 246</u>				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>HARRY BREYON DAVIS</u>				4 DATE OF DEATH Month Day Year <u>July 21 1967</u>			
5 SEX <u>M</u> COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Nov 13 1900</u>		9 AGE (In years last birthday) <u>66</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11 BIRTHPLACE (State or foreign country) <u>Williams Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>VIRGIL DAVIS</u>				14 MOTHER'S MAIDEN NAME <u>SARA MARGARET CLARK</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>217-36-0827</u>		17 INFORMANT Address <u>MRS DAVIS (WIFE) Whaleyville, Md.</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>72+1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY EDEMA, Acute</u> <u>ASCUD</u> (c) <u>13 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr</u>		M.D. <u>F.J. Townsend, Jr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (State, city or town, or county) <u>Ocean City Md</u>		22. DATE SIGNED <u>July 21, 1967</u>	
23a BURIAL OR CREMATION Specify (Type) <u>Burial</u>		23b DATE THEREOF <u>7/23/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>State</u>		23d LOCATION (City or town) (County) (State) <u>Whaleyville Worcester, Md.</u>	
24 FUNERAL DIRECTOR <u>Peter Whaley Selbyville, Del.</u>		ADDRESS <u>1967</u>		25a REC'D BY REGISTRAR <u>JUL 25 1967</u>		b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

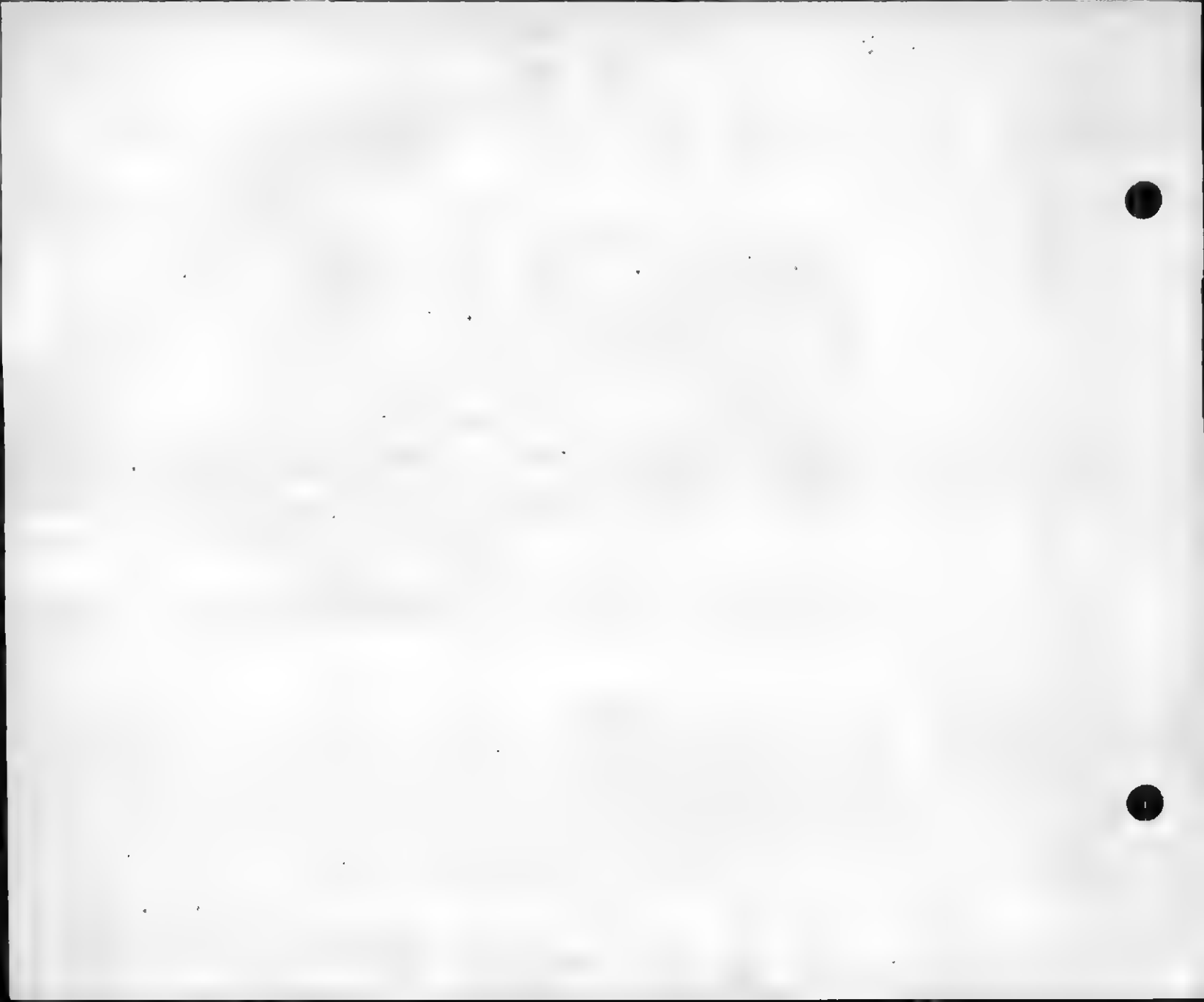
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b> c. LENGTH OF STAY IN 1b <b>38 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>XX</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b> d. STREET ADDRESS <b>RFD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Katherine D. Day</b>		4. DATE OF DEATH <b>July 1, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1870</b>
9. AGE (in years last birthday) <b>96</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Day</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b>		16. SOCIAL SECURITY NO. <b>220-52-7971</b>	
17. INFORMANT <b>Flora McCabe</b>		Address <b>Bishopville, Md. RFD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cremia</b> DUE TO (b) <b>Congestive Heart Failure</b> DUE TO (c) <b>10 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1961, to <b>July</b> , 1967, that (I) (we) last saw the deceased alive on <b>July 15, 1967</b> , and that death occurred at <b>4A-M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank E. Gantz Jr.</b>		22b. DATE SIGNED <b>7/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank E. Gantz Jr.</b>		22d. ADDRESS <b>5 Bay St. Berlin Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>		23b. DATE THEREOF <b>7/3/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>		23d. LOCATION (City, town or county) (State) <b>Bishopville, Md.</b>	
24. FUNERAL DIRECTOR <b>Peter Whaley Seligman, Del.</b>		25a. REC'D BY REGISTRAR <b>JUL 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

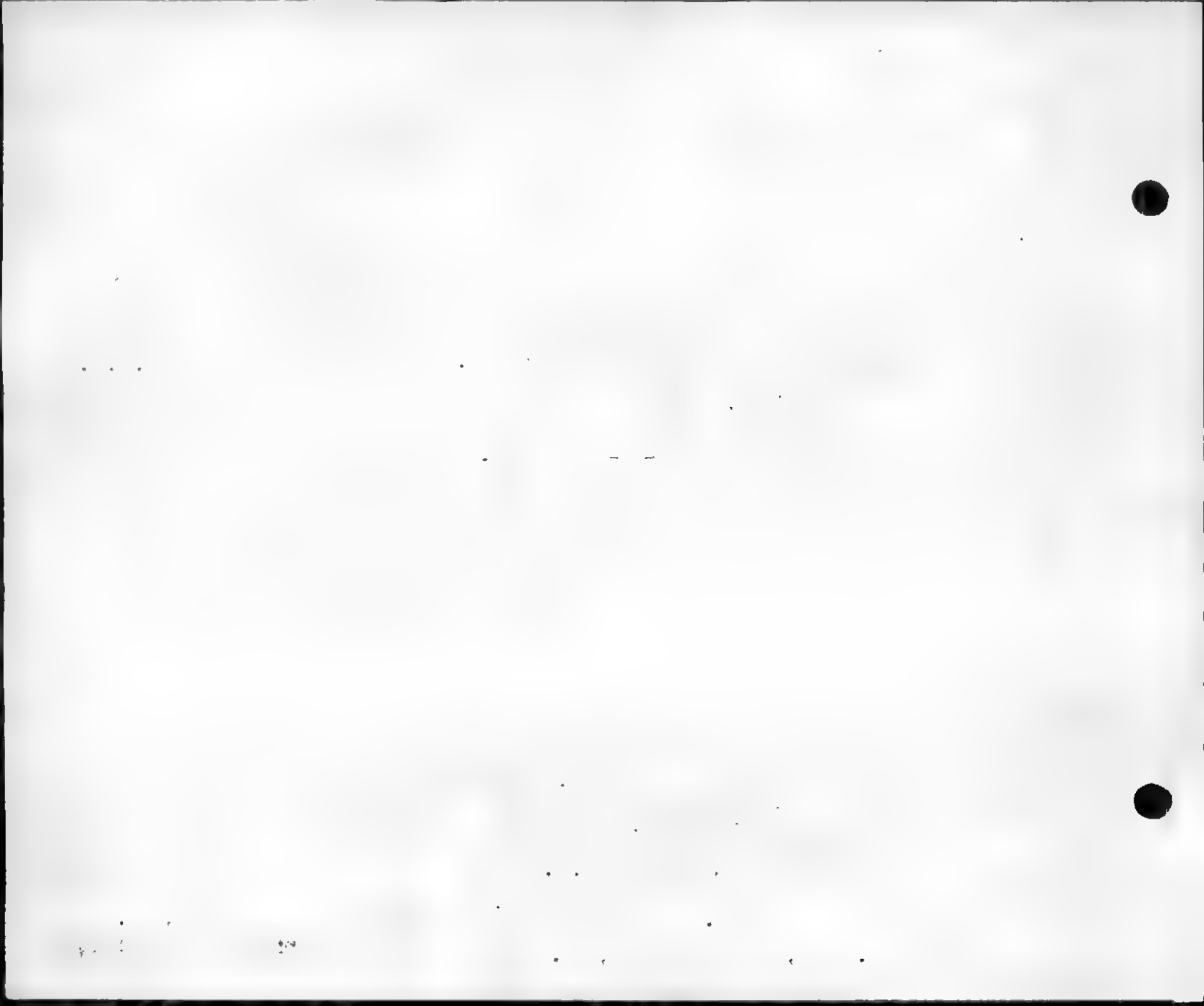
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10320

10320

1 PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pocomoke River</b>				e. STREET ADDRESS <b>114 Doncaster Road</b>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>MELVIN RUSSELL DICKEY</b>				4 DATE OF DEATH Month Day Year <b>July 10, 1967</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 22, 1918</b>	9 AGE (In years last birthday) <b>49 yrs</b>	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Melvin R. Dickey</b>				14. MOTHER'S MAIDEN NAME <b>Aurinthia Adkins</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W W 2</b>		16 SOCIAL SECURITY NO <b>215-10-3260</b>		17 INFORMANT <b>Mrs. Gladys Dickey</b>		Address (Same)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACCIDENTAL DROWNING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>DUE TO</b> (c) <b>DUE TO</b>						INTERVAL BETWEEN ONSET AND DEATH <b>NONE</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19 WA. A. TOXIC PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Robert C. LaMar, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Snow Hill,		22. DATE SIGNED <b>7/13/67</b>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Maryland		Address (Street, city, town or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/17/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Baltimore, Md.</b>	
24 FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Baltimore, Md. 21214</b>				25a. REC'D BY REGISTRAR <b>JUL 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/66

10321

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c LENGTH OF STAY in 1b <u>3 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Street</u>		d STREET ADDRESS <u>1270 Jefferson Blvd</u>	
3 NAME OF DECEASED (Type or print) <u>James Richard Dwyer</u>		DATE OF DEATH <u>July 7 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 9, 1915</u>
9 AGE (In years last birthday) <u>51</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surgeon</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	
11 BIRTHPLACE (State or foreign country) <u>Renovo, Penn</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>FRANK P. Dwyer</u>		14 MOTHER'S MAIDEN NAME <u>MARY Howell</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>WW II</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>220-44-4554</u>	
17 INFORMANT <u>Mrs. James Dwyer (wife)</u>		Address <u>Hagerstown.</u>	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>ASCVD with coronary sclerosis</u> (b) <u>ASCVD with coronary sclerosis</u> (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>		ASSISTANT MED. EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b DATE THEREOF <u>7-10-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>	
24 FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>		25a REC'D BY REGISTRAR <u>JUL 11 1967</u>	
ADDRESS		25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10322

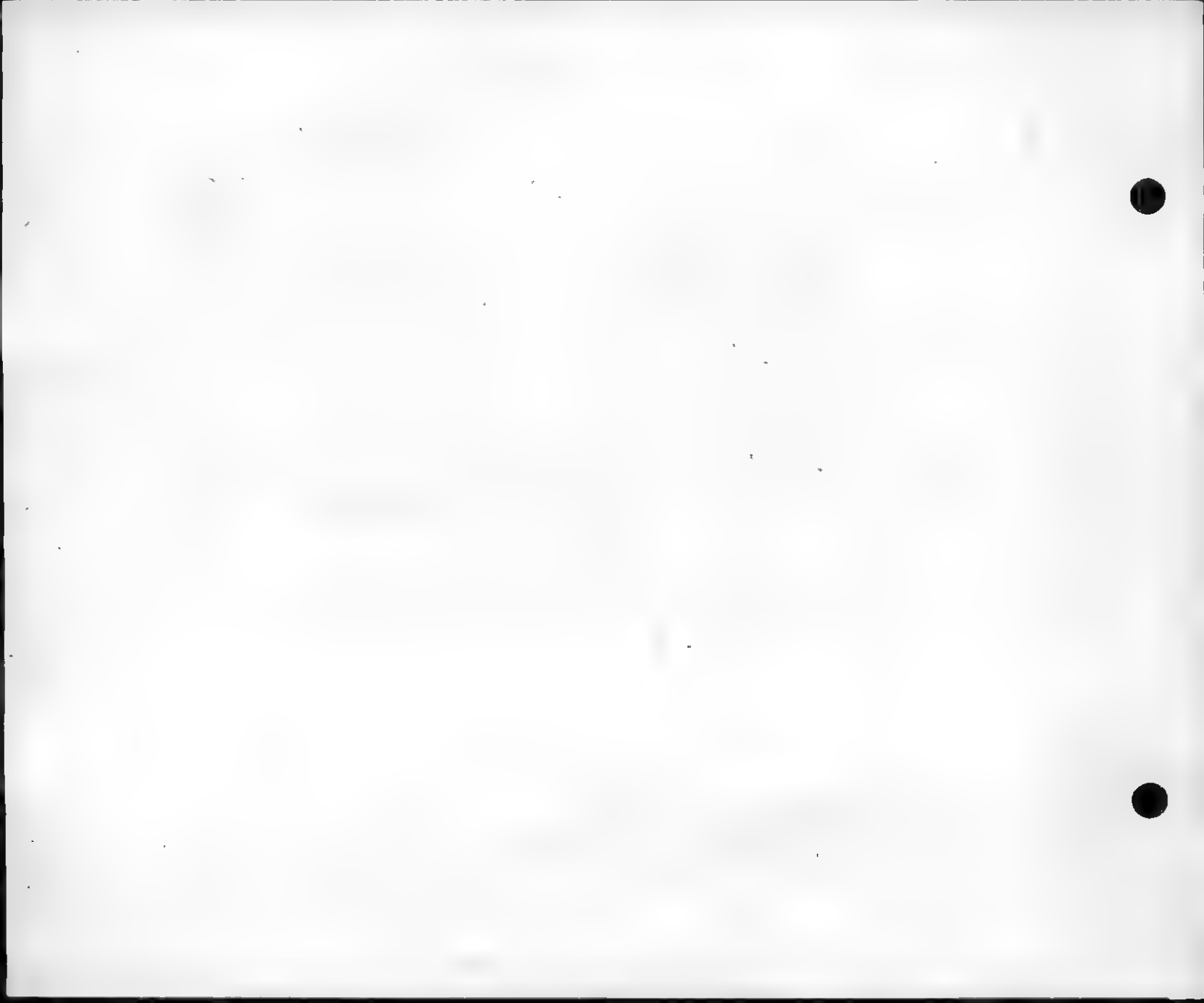
10322

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <u>Pennsylvania</u> b COUNTY <u>Westmoreland</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c LENGTH OF STAY IN 1b <u>3 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Quality Motel</u>		e CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>New Kensington</u>	
3 NAME OF DECEASED (Type or print) <u>HAROLD ARTHUR FARKAS</u>		f STREET ADDRESS <u>1016 PARK View Drive</u>	
4 DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1967</u>	g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>APRIL 13, 1918</u>
9 AGE (in years last birthday) <u>49</u> yrs	10 FUND 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u>19</u> Min <u>67</u>	11 IF UNDER 24 HRS Months <u>4</u> Days <u>11</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Merchant</u>	10b KIND OF BUSINESS OR INDUSTRY <u>Food</u>	11 BIRTHPLACE (State or foreign country) <u>BRACKENRIDGE, PA.</u>	12 CITIZEN OF WHAT COUNTRY? <u>USA</u>
13 FATHER'S NAME <u>MAX FARKAS</u>		14 MOTHER'S MAIDEN NAME <u>ROSE FRIEDMAN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16 SOCIAL SECURITY NO <u>167-07-5111</u>	
17 INFORMANT <u>Joanne FARKAS, wife</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>CORONARY Occlusion Acute</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ASCUD</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F.S. Townsend, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F.S. Townsend, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22 DATE SIGNED <u>July 11, 1967</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL (CREMATION, REMOVAL) (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>7/14/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>CHERBA KADISHA</u>	23d LOCATION (City or town) <u>LOWER BURRELL</u>
24 FUNERAL DIRECTOR <u>Arthur A. Burdage</u>		25a REC'D BY REGISTRAR <u>JUL 13 1967</u>	
25b ADDRESS <u>Berlin Md.</u>		25c REG. NO. & SIGNATURE	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10323

1967

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Worcester</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>423 Covington St.</u>				d. STREET ADDRESS <u>423 Covington St.</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sara H. Fisher</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>27</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 11, 1887</u>							
<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1"> <tr> <td>UNDER 1 YEAR</td> <td>UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		UNDER 1 YEAR	UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>House Work</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md.</u>	
UNDER 1 YEAR	UNDER 24 HRS.												
Months	Days												
Hours	Min.												
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Eric Collick</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-14-1335</u>		<b>17. INFORMANT</b> <u>Edwin Fisher</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Generalized arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) 		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>							
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) 		<b>20f. [City or town]</b> (County) (State) 									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>July 25, 1967</u> <b>to</b> <u>July 27, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>July 25, 1967</u> <b>and that death occurred at</b> <u>10 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>David Rafat</u>		<b>22b. DATE SIGNED</b> <u>7-28-67</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>DAVID RAFAT</u>		<b>22d. ADDRESS</b> <u>Snow Hill Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7-31-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Coolspring Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Girdletree Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Amos Savage</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 1 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. [illegible]</u>									



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10324

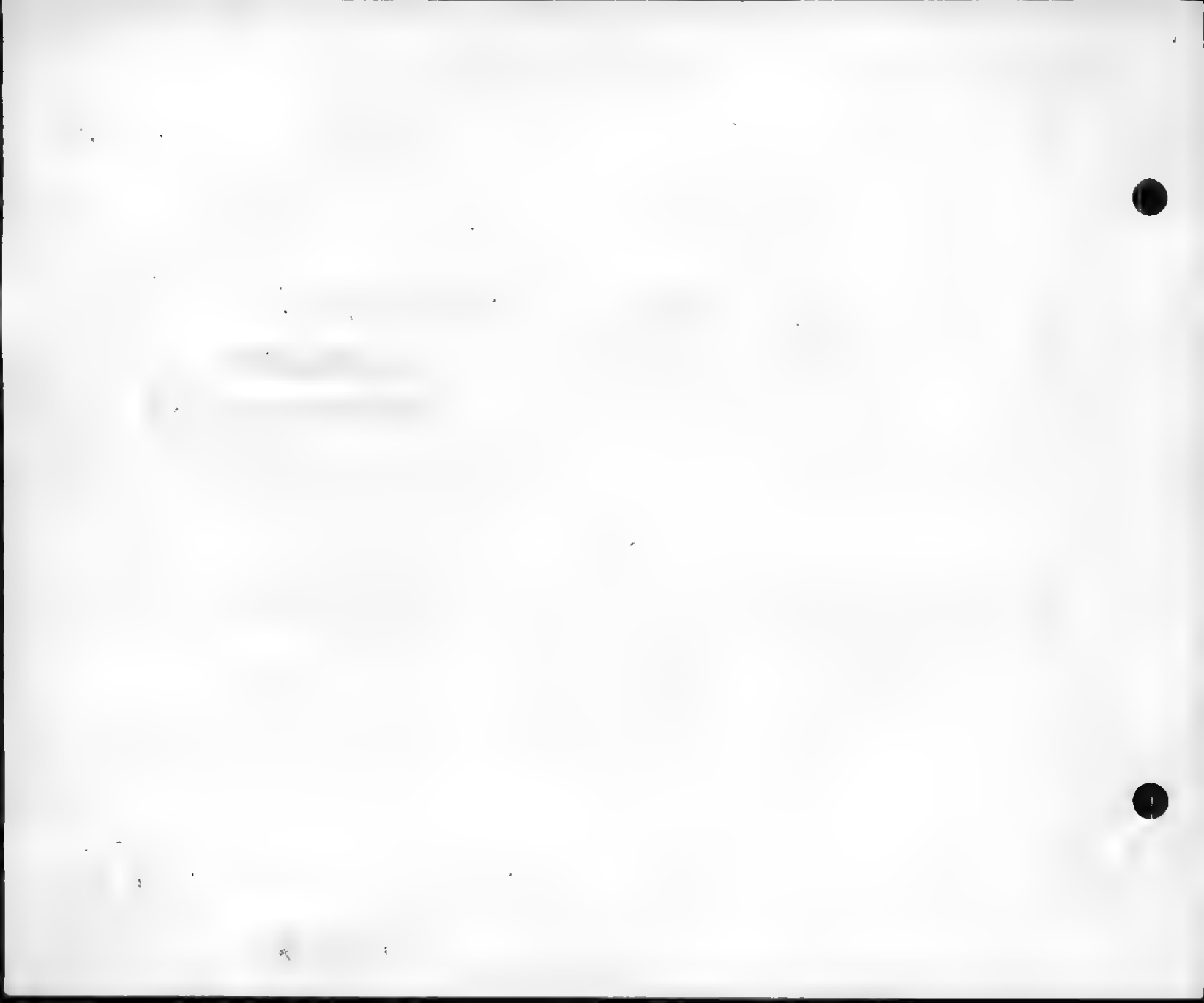
10324

FOR STATE HEALTH DEPT.

This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY in 1b <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA 1001 Phila Ave</u>		d. STREET ADDRESS <u>604 Crest View</u>	
3 NAME OF DECEASED (Type or print) First <u>EUNICE</u> Middle <u>G</u> Last <u>IVARZ</u>		4 DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-7</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>FRANCIS Heilig</u>		14 MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>UNKNOWN</u>	
17 INFORMANT <u>503 River View Ave</u>		<u>Salisbury, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR Collapse - Myocardial Infarct</u> DUE TO (b) <u>ASCVD with hypertension</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>RM Hughes</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R M Hughes, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. DATE OF CREMATION (Specify) <u>7-24-67</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Beth Israel</u>		23d. LOCATION (City or town) (County) (State) <u>Salisbury, Md.</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros</u>		25. REGISTRAR'S SIGNATURE <u>JUL 28 1967</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (1)  
6M 1/67

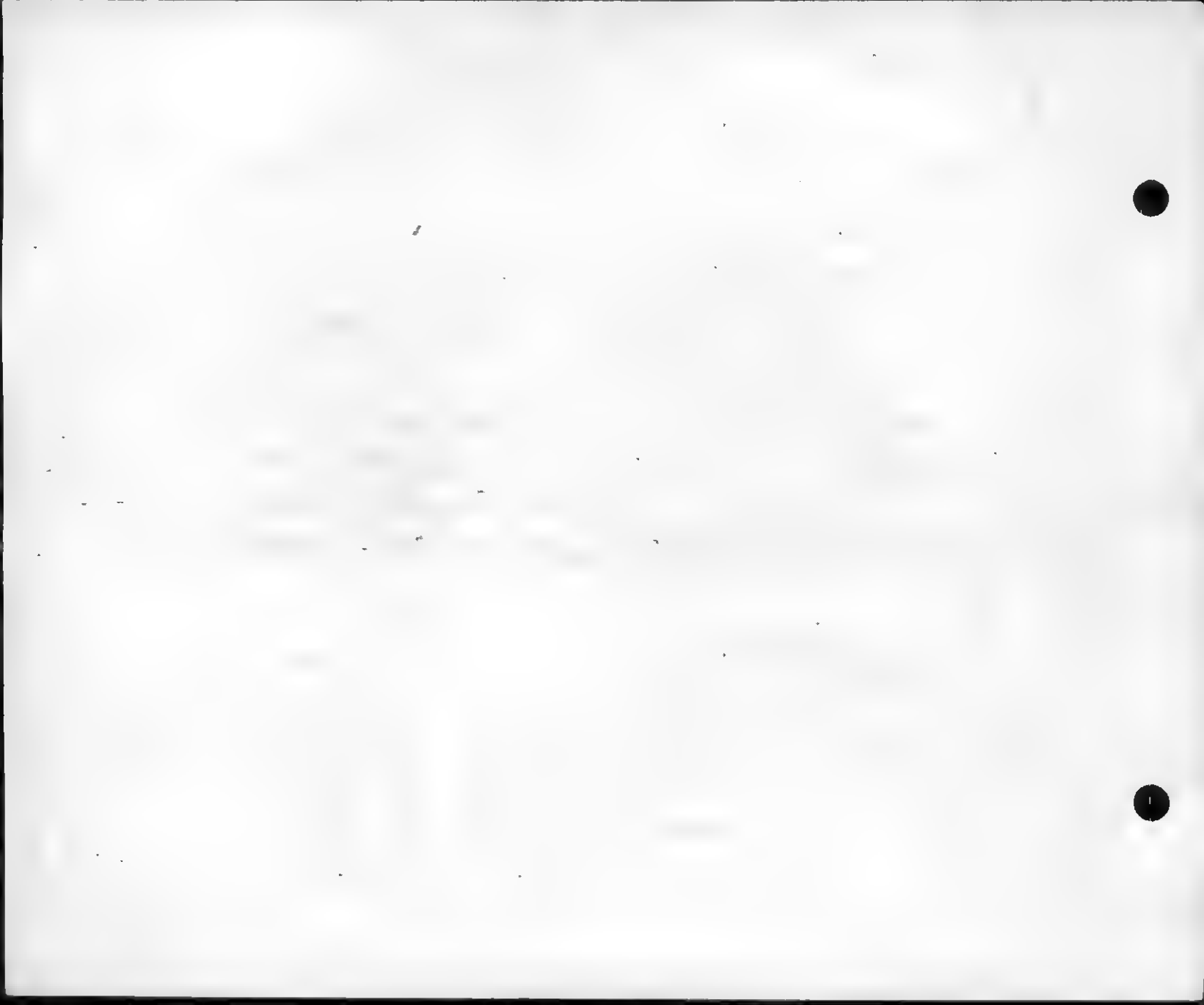
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10226

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10325

1. PLACE OF DEATH a COUNTY <b>Worcester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a STATE <b>MD.</b> b COUNTY <b>WOR.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>		c LENGTH OF STAY in 1b <b>4 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9 CAROLINE ST</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>	
f STREET ADDRESS <b>9 CAROLINE ST</b>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>WINFIELD CARL JOHNSON</b>		4 DATE OF DEATH Month Day Year <b>July 8 1967</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JUNE 16, 1905</b>
9 AGE (In years last birthday) <b>62 yrs</b>		10 IF UNDER 1 YEAR Months Days Hours Mins <b>62</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>	
11 BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>John J. Johnson</b>		14 MOTHER'S MAIDEN NAME <b>Josephine SWANSON</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>577-12-8056</b>	
17 INFORMANT <b>Mrs Dorothy Johnson, wife,</b>		Address <b>Ocean City, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>W L U I</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ACUTE</b> (c) <b>Coronary Occlusion, Acute</b> <b>ASCVD with Coronary &amp; Myocardial failure 3 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above. I held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>F J Townsend, Jr</b>		22. DATE SIGNED <b>July 8, 1967</b>	
EXAMINER'S NAME (Type) <b>F J TOWNSEND, JR MD</b>		Address (Street, City or Town, County) <b>Worcester County</b>	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>7-11-67</b>	23c NAME OF CEMETERY OR REPOSITORY <b>SUNSET MEMORIAL</b>	23d LOCATION (City or Town) (County) (State) <b>BERLIN, WORCESTER, MD.</b>
24 FUNERAL DIRECTOR <b>WILLIAMS FUNERAL HOME</b>		25a REC'D BY REGISTRAR <b>JUL 12 1967</b>	
ADDRESS <b>BERLIN, MD.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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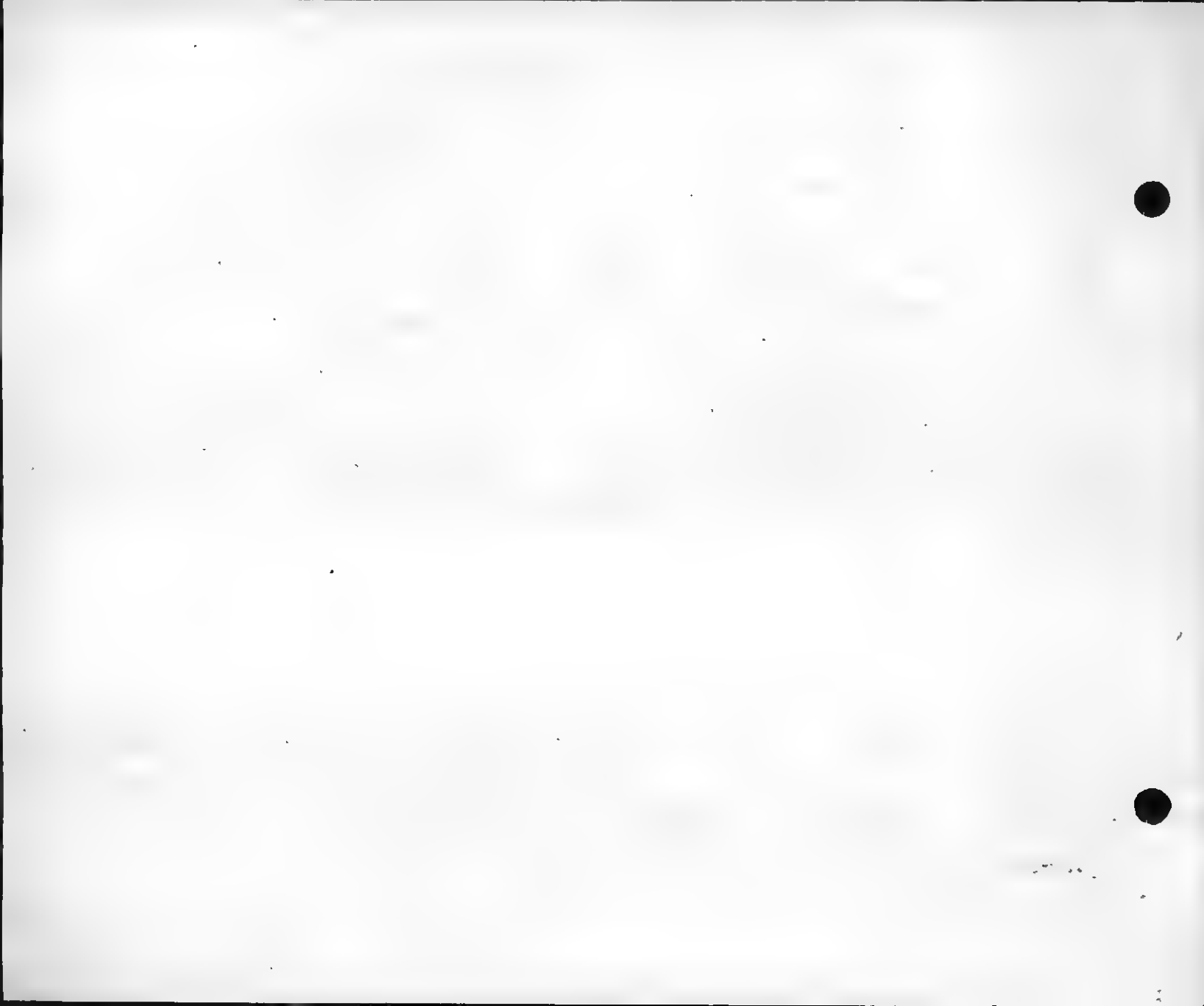
FOR STATE HEALTH DEPT.

10326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10326

1 PLACE OF DEATH a COUNTY <u>Worcester</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> c LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived if institution Reside before admission) a STATE <u>VIRGINIA</u> b COUNTY <u>FAIRFAX</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VIENNA</u> d STREET ADDRESS <u>8333 WESLEYAN ST.</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>DONALD</u> First <u>ELMER</u> Middle <u>KRAMER</u> Last 5 SEX <u>M</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAN</u> 10b KIND OF BUSINESS OR INDUSTRY <u>VACATION HOME</u>		4 DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u> 8 DATE OF BIRTH <u>22 MARCH 1920</u> 9 AGE (in years last birthday) <u>47</u> 11 BIRTHPLACE (State or foreign country) <u>ERIE PA.</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>HERMAN CRIMER</u> 14 MOTHER'S MAIDEN NAME <u>EDNA MAE MILLER</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>YES</u> (If yes give war or date of service) <u>WWII from 1945-07-623</u> 16 SOCIAL SECURITY NO <u>295-07-623</u> 17 INFORMANT <u>Pamela Kramer</u> Address <u>8333 Wesleyan St. Vienna</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>11/11 DROWNING</u> Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1218</u> DUE TO (c) <u>1218</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>limited</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) <u>None Known</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>TI</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Accident</u>	
20c TIME OF INJURY Month Day Year <u>7-30-67</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home or factory street or beach etc.) <u>BEACH</u>	
20f (City or town) <u>Ocean City</u> (County) <u>Worcester</u> (State) <u>MD.</u>		20g (City or town) <u>Ocean City</u> (County) <u>Worcester</u> (State) <u>MD.</u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip P. Brous</u> EXAMINER'S NAME (Type) <u>PHILIP P. BROUS</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1001 PHILADELPHIA Ave. Address (Street city town or county) <u>Ocean City</u>	
23a BURIAL CREMATION REMAINS (Specify) <u>Cremation</u> 23b DATE THEREOF <u>8/1/67</u> 23c NAME OF CEMETERY OR CREMATORY <u>SILVERBROOK</u>		23d LOCATION (City or town) <u>WILMINGTON</u> (County) <u>DEL</u> (State) <u>DE</u>	
24 FUNERAL DIRECTOR <u>Anna A. Buehage</u> Address <u>Bulin Md</u>		25c REC'D BY REGISTRAR <u>Charles Judge</u> 25d REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 File #3-21-1967

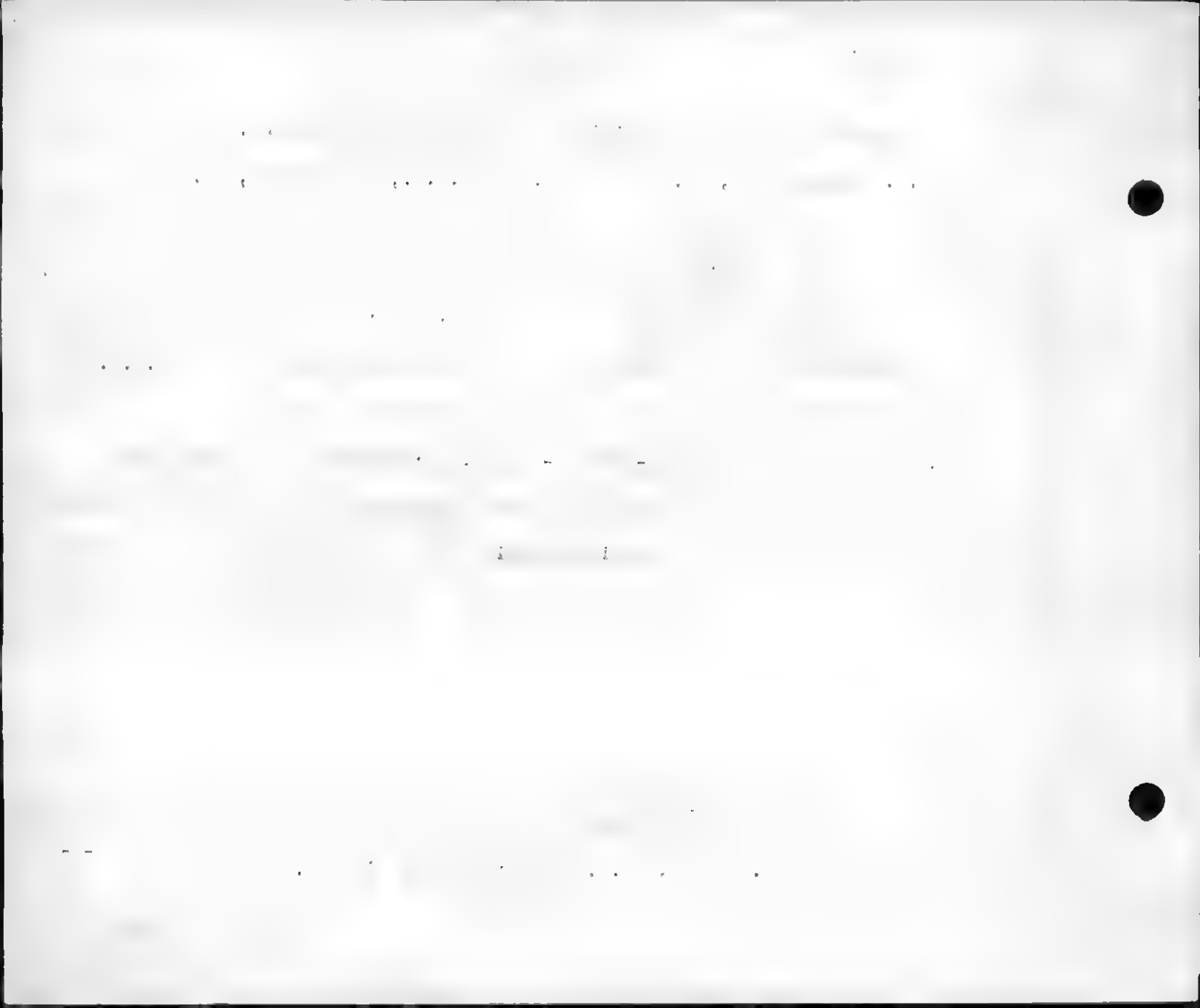
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10327

10327

FOR STATE HEALTH DEPT

1 PLACE OF DEATH a COUNTY <b>Worcester</b> <b>Whaleyville, MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Whaleyville, Md.</b> b COUNTY <b>Worcester</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D., Whaleyville, Md.</b>				c LENGTH OF STAY IN 1b <b>88 yrs.</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				e STREET ADDRESS			
f RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <b>Mollie E. Lewis</b>			4 DATE OF DEATH Month <b>7</b> Day <b>31</b> Year <b>1967</b>				
5 SEX <b>F</b>		6 COLOR OR RACE <b>W</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Dec. 16, 1879</b>	
9 AGE (In years last birthday) <b>87</b>		10 IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b>		11 IF UNDER 24 HRS Hours <b>8</b> Min <b>8</b>			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11 BIRTHPLACE (State or foreign country) <b>Whaleyville, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13 FATHER'S NAME <b>David Evans</b>				14 MOTHER'S MAIDEN NAME <b>Charlotte Daisy</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16 SOCIAL SECURITY NO <b>222-182-140-D</b>		17 INFORMANT <b>Mrs. Ella Lewis</b>	
				Address <b>Bishop, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 hrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)							
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Robert C. La Mar</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>ROBERT C. LA MAR, MD.D. 106 bay st Snow Hill, Md.</b>				ASSTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				22. DATE SIGNED <b>8-2-67</b>			
23a BURYAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b DATE THEREOF <b>8/3/67</b>		23c NAME OF CEMETERY OR CREMATORY <b>PENOBSCOT</b>	
24 FUNERAL DIRECTOR <b>Anna R. Burbox Berlin Md</b>				25a REC'D BY REGISTRAR <b>DATE AUG 7 1967</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

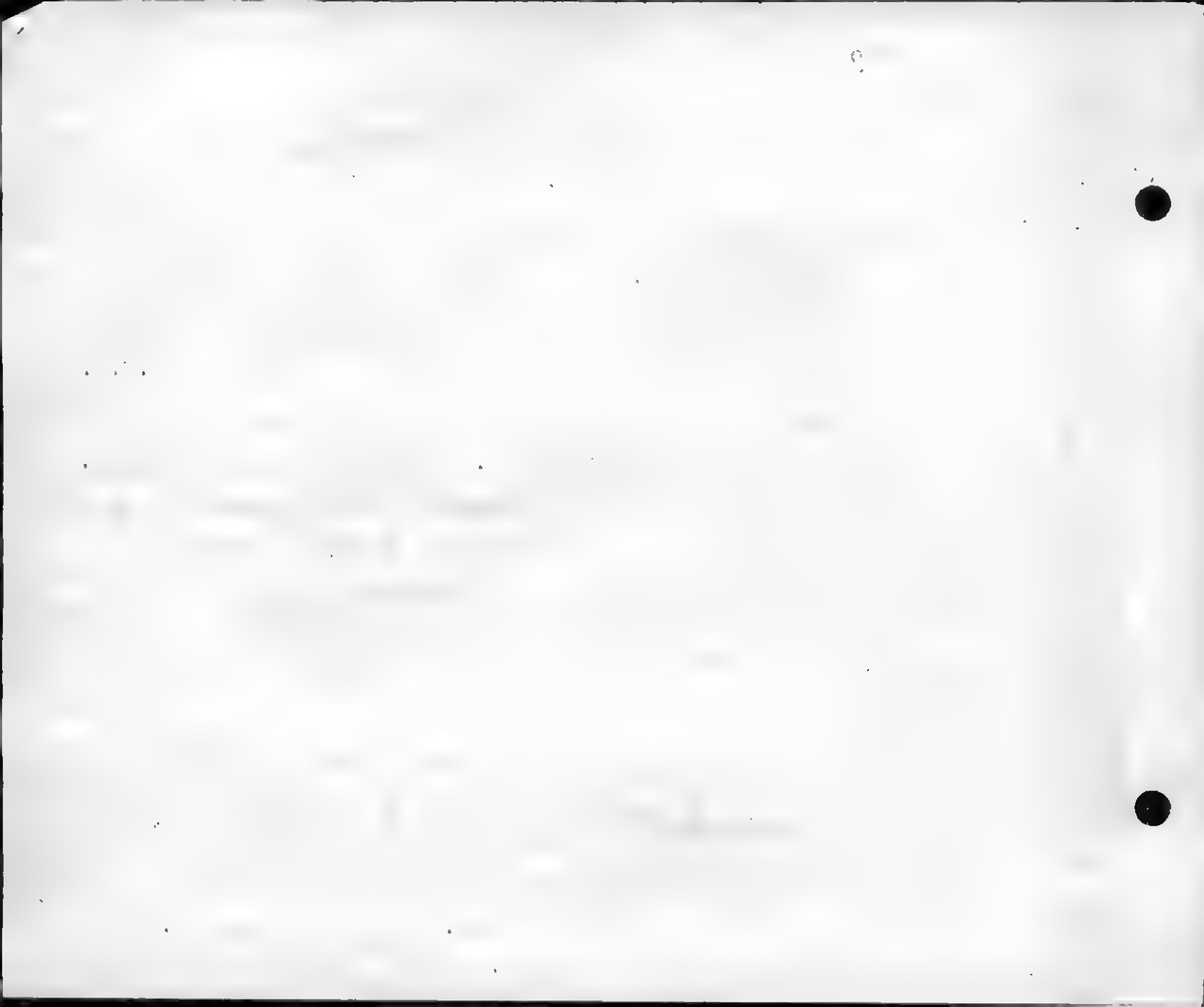
10328

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10328

1 PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stockton</b>			c. LENGTH OF STAY IN ID <b>4 Mons.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holland's Nursing Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNIE P. MASON</b>				4. DATE OF DEATH <b>July 13, 1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 31, 1886</b>		9. AGE (In years last birthday) <b>81</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Storekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Worcester, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silas Payne</b>				14. MOTHER'S MAIDEN NAME <b>Roberta Townsend</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>219-05-7351</b>		17. INFORMANT Address <b>Mrs. Louise Tarr, Snow Hill, Md.</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> <b>4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart-</b> DUE TO (c) <b>Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b>  <b>Years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>—</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 1961, to <b>July 1967</b> , that (I) (we) last saw the deceased alive on <b>July 7</b> , 1967, and that death occurred at <b>7</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>David Rafat</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/13/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David Rafat MD</b>				22d. ADDRESS <b>Snow Hill, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/15/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Stockton, Md.</b>		
24. FUNERAL DIRECTOR <b>Thomas E. Thomas</b>				25a. REC'D BY REGISTRAR <b>JUL 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10329

11746

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishopville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Alfred Melson</u>				4. DATE OF DEATH Month Day Year <u>7 29 1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/1905</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>L. Alfred Melson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Melson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War II</u>		17. INFORMANT <u>Grace Melson (Wife)</u>		Address <u>Bishopville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 4201 DUE TO (b) <u>coronary atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Mar. 2, 1964 to July 29, 1967</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 2, 1964</u> to <u>July 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr. 23, 1967</u> , and that death occurred at <u>3P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Jack C. Lewis</u>				22b. DATE SIGNED <u>Aug. 12, '67</u>		22c. PHYSICIAN'S NAME (Type) <u>Jack C. Lewis, M. D.</u>	
22d. ADDRESS <u>Selbyville, Delaware</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/1/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bishopville, Maryland</u>	
24. FUNERAL DIRECTOR <u>George Melson, Frankford, Del.</u>				25a. REC'D BY REGISTRAR <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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FOR STATE HEALTH DEPT

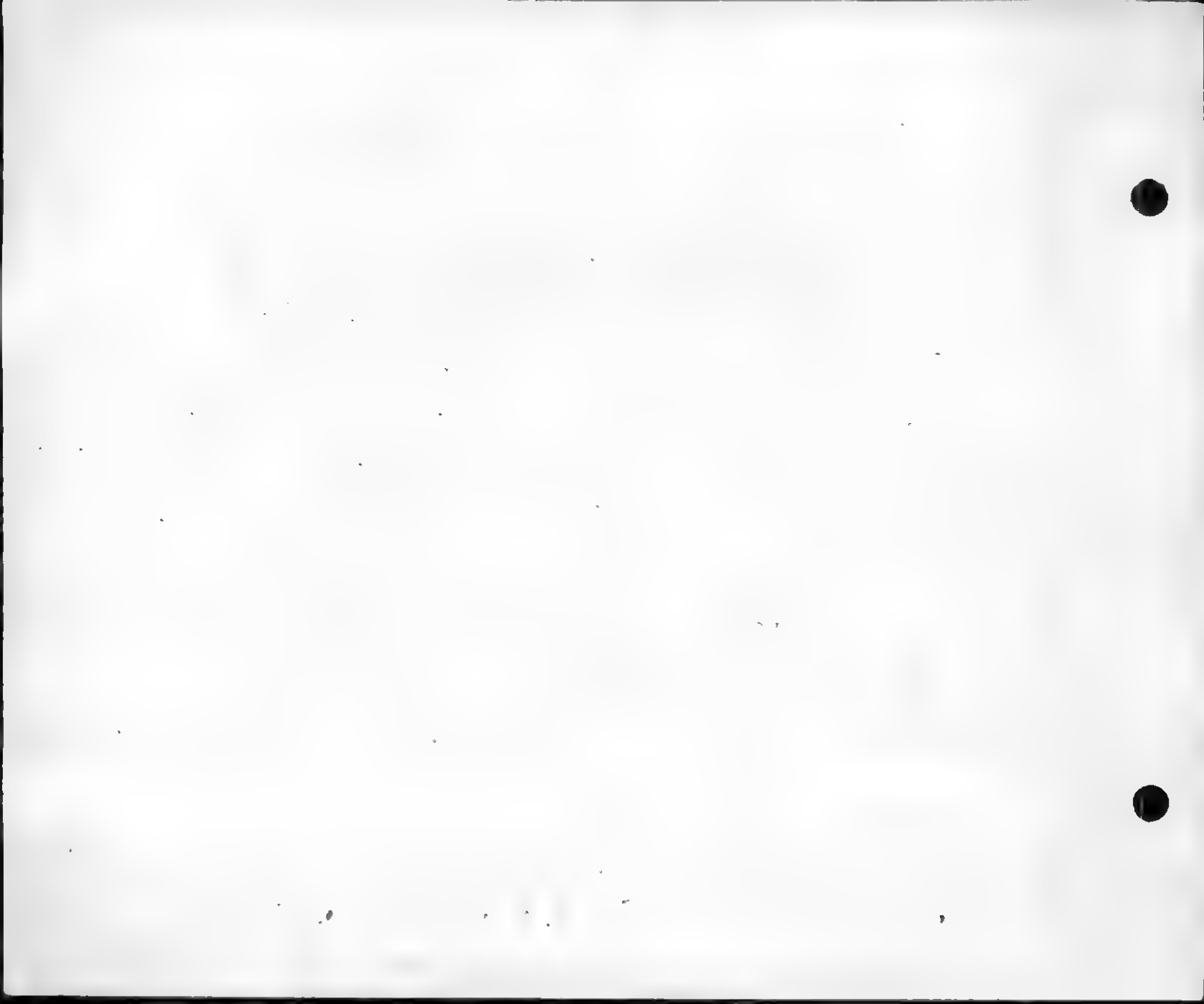
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10330

33529

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>Wor</u>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Berlin-Rural</u>				c LENGTH OF STAY IN b <u>1 hour</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hickory Ridge Road</u>				e STREET ADDRESS <u>—</u>			
3 NAME OF DECEASED (Type or print) <u>John Levin Mumford JR</u>				4 DATE OF DEATH <u>July 9 1967</u>			
5 SEX <u>M</u>	6 CO. OR OR RACE <u>N</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 14, 1928</u>	9 AGE (In years) <u>38</u> yrs	10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>John Levin Mumford</u>				14 MOTHER'S MAIDEN NAME <u>Nancy Pitts</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>218-24-2587</u>		17 INFORMANT <u>Corp. SANDRAFFEE</u> Address <u>State Police Salisbury</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GUN SHOT WOUND chest (long)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>IX</u> DUE TO (b) <u>INTERVAL BETWEEN ONSET AND DEATH (APPROX) 5 minutes</u> DUE TO (c) <u>(APPROX)</u>				PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year <u>230 - Aug 9 1967</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>Street</u>		20f (City or town) (County) (State) <u>Rural Berlin Wor MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Richard T. Watson</u>		EXAMINER'S NAME (Type) <u>F. J. Cowan, JR</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22 DATE SIGNED <u>Aug 12, 67</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		23b DATE THEREOF <u>7/13/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Sarah Dukes Cem</u>		23d LOCATION (City or town, County) (State) <u>Bishop Wor. Md.</u>	
24 FUNERAL DIRECTOR <u>Richard T. Watson</u>		ADDRESS <u>Salisbury, Del.</u>		25a REC'D BY REGISTRAR <u>JUL 19 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1

FOR STATE HEALTH DEPT.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10331

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10331

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Jewell</u> Middle <u>B</u> Last <u>Northam</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 1904</u>	9. AGE (in years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u> Hours <u>15</u> Min <u>00</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Burge</u>				14. MOTHER'S MAIDEN NAME <u>Alice Hatfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>S. Otis Northam, Snow Hill, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE CORONARY OCCLUSION</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>01</u> pm <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Robert C. La Mar</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. EXAM. <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED <u>7/28/67</u>	
EXAMINER'S NAME (Type) <u>Robert C. La Mar, M. D., 104 Bay Street, Snow Hill, Md.</u>							
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 29 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Meth.</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Md.</u>	
24. FUNERAL DIRECTOR <u>Norman F. Herring, Snow Hill, Md.</u>				25a. RECEIVED BY REGISTRAR <u>JUL 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



1  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

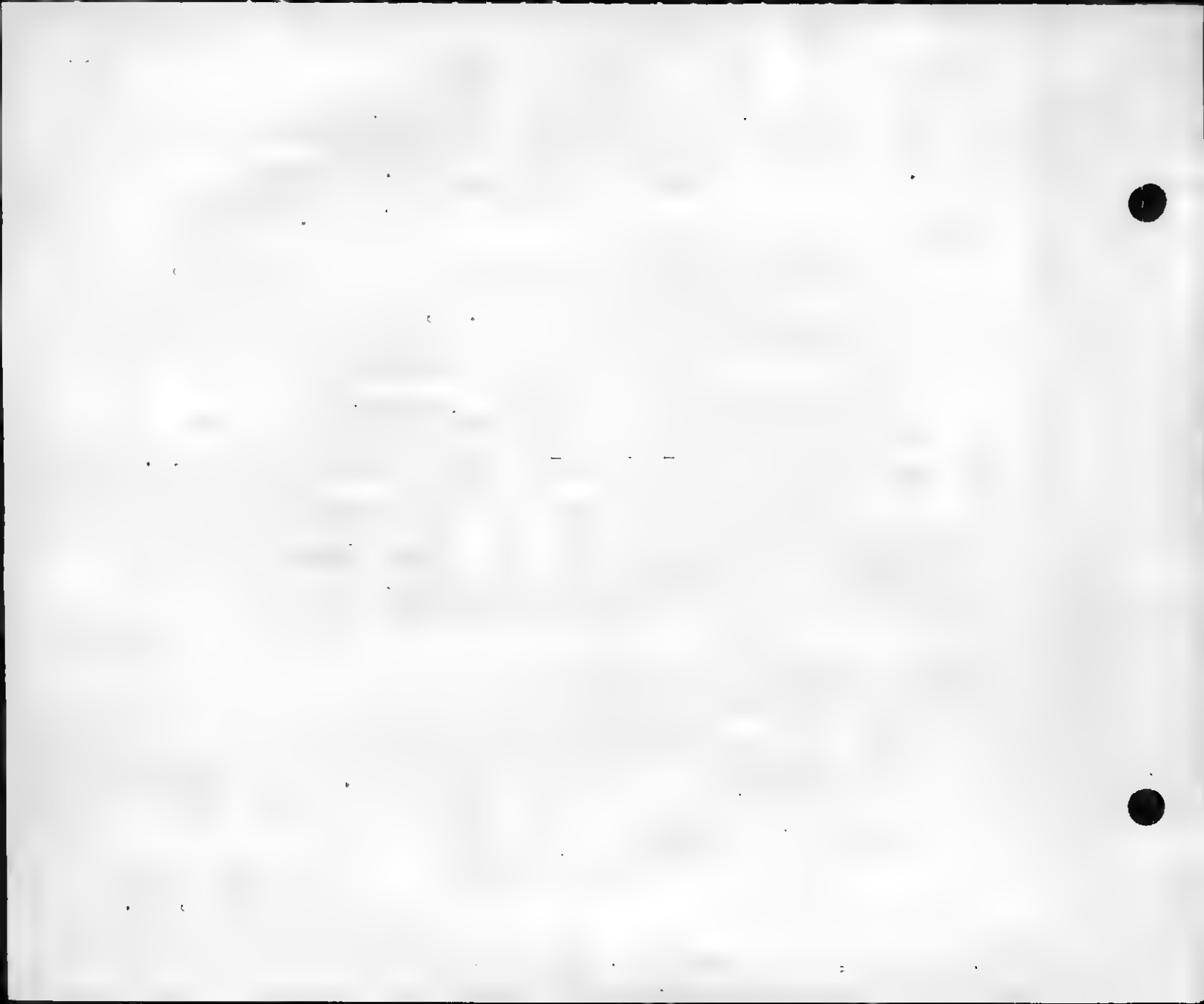
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10332

10331

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Martins</b>		c. LENGTH OF STAY IN ID <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Martins</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Berlin, Md. RFD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>Adkins</b> Last <b>Scott</b>			4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1967</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1884</b>	9. AGE (in years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Noah Adkins</b>			14. MOTHER'S MAIDEN NAME <b>Rittie Baker</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>213-18-4108-11</b>		17. INFORMANT <b>George Adkins Berlin, Md.</b>		Address <b>RFD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>5X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Scleroderma</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-1-60</b> , 19 <b>67</b> , to <b>7-28-67</b> , that (I) (we) last saw the deceased alive on <b>7-10</b> , and that death occurred at <b>5A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clifford E. Scholtz</b>				22b. DATE SIGNED <b>7-30-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Clifford E. Scholtz MD Berlin, Md.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE THEREOF <b>7/30/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dale</b>		23d. LOCATION (City, town or county) (State) <b>Whaleyville, Md.</b>	
24. FUNERAL DIRECTOR <b>Peter Whaley Selbyville, Del.</b>				25a. REC'D BY REGISTRAR <b>JUL 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10333

CERTIFICATE OF DEATH

10322

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>209 Linden Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Simpkins</u> Last <u>Simpkins</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12 1895</u>
9. AGE in years <u>71</u>		10. UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>FLA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Gua Wix Pocomoke, Md.</u>		Address <u>209 Linden Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CORONARY INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>LUETIC AORTIC INSUFFICIENCY</u> DUE TO (c) <u>TETIARY LUES.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-5 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>GEN. ART. SCLEROSIS.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>64</u> , to <u>7/7</u> , 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>19/11</u> , 19 <u>64</u> , and that death occurred at <u>11:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Neville A. Baron</u> M.D.		22b. DATE SIGNED <u>7/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>		22d. ADDRESS <u>Pocomoke, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Bapt. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Princess Anne, Md.</u>
24. FUNERAL DIRECTOR <u>Samuel S. Sauer</u>		25a. REC'D BY REGISTRAR <u>New Church, Va.</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>		DATE <u>JUL 12 1967</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

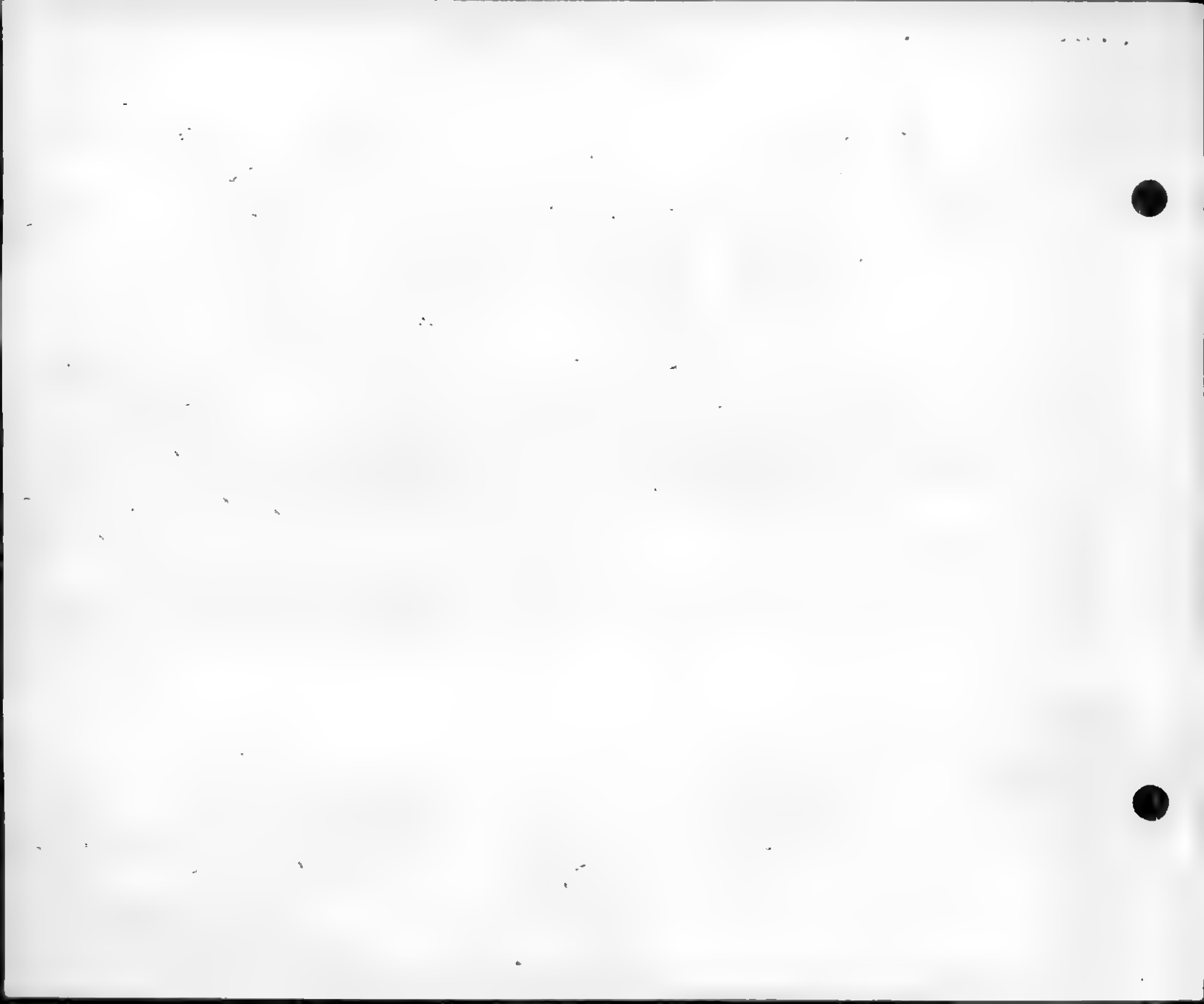
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10333

1 PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY N 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> 02:2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stowaway Motel Parking lot.</u>				d. STREET ADDRESS <u>Glenwood Ave 409</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Herbert Andrew Straitz</u>				4 DATE OF DEATH <u>July 11 1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-30-26</u>	9 AGE (In years last birthday) <u>40</u> yrs.	F UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick G. Straitz</u>				14. MOTHER'S MAIDEN NAME <u>MARtha E Schmidt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Korea</u>		16. SOCIAL SECURITY NO <u>217-20-0235</u>		17. INFORMANT <u>MRS Gloria M Straitz wife.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY Occlusion, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD -</u> (c) <u>UNKNOWN.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>F S Townsend Jr</u>		EXAMINER'S NAME (Type) <u>F S Townsend Jr</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>July 11 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>14 July 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>				25a. REG. BY REGISTRAR <u>JUL 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



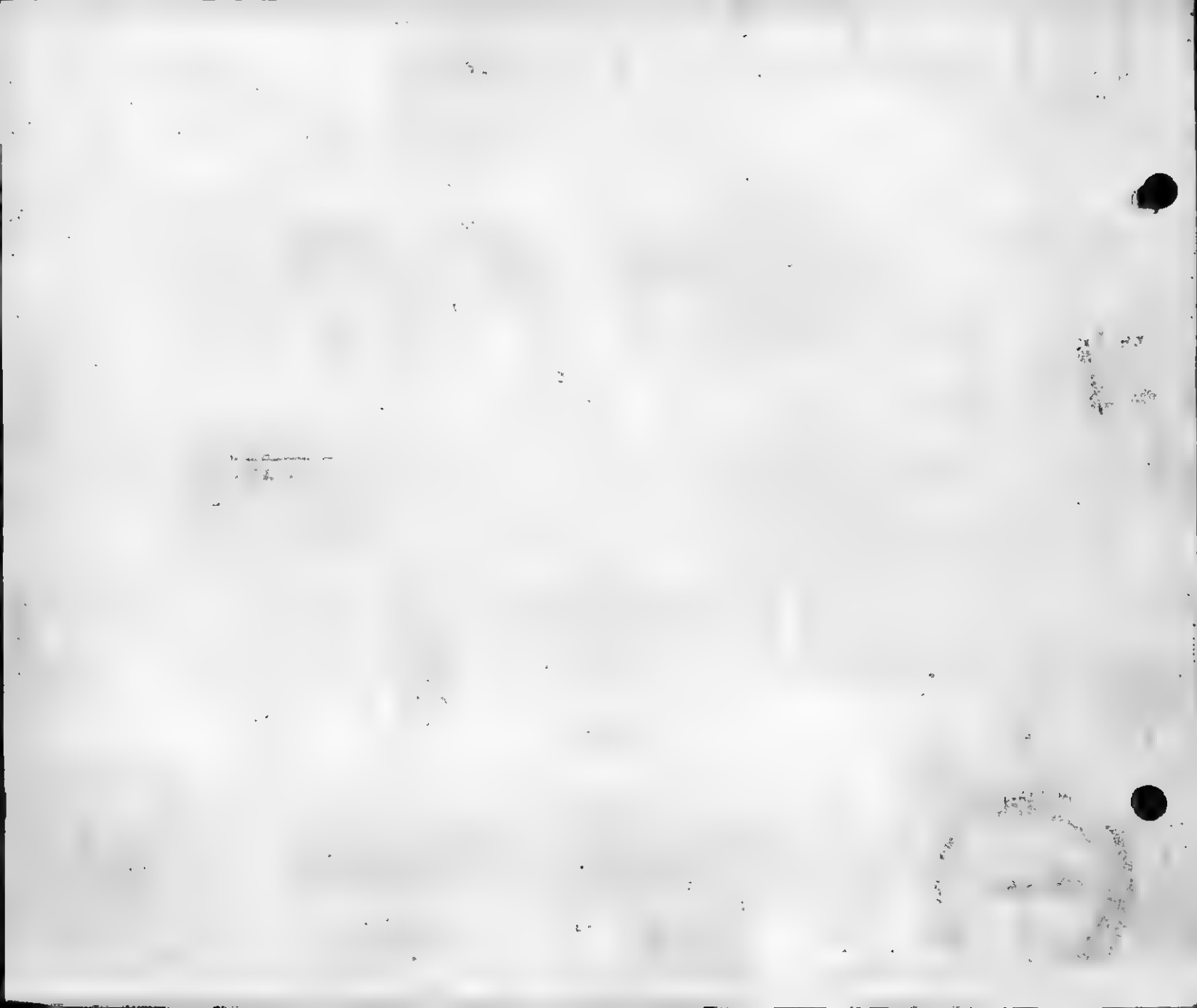
## CERTIFICATE OF DEATH

Reg. Dist. No.

10334

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wenona	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 819 Second St		d. STREET ADDRESS Main Road	
3. NAME OF DECEASED (Type or print) First Middle Last Soda Tawes		4. DATE OF DEATH Month Day Year July 25 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1879
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Household	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alexander White	
14. MOTHER'S MAIDEN NAME Amanda White		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Orville LaCurts Pocomoke City MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hours years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis. Degenerative Heart Disease			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr. 18, 1967, to July 25, 1967, that I last saw the deceased alive on July 25, 1967, and that death occurred at 10:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles W. Trader		ADDRESS (Street, city or town, state) 302 Market Street, Pocomoke City, Maryland	
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		DATE SIGNED 7-26-67	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/67	
22c. NAME OF CEMETERY OR CREMATORY St Johns Cemetery		22d. LOCATION (City, town, or county) Deal Island Md	
23. FUNERAL DIRECTOR'S SIGNATURE Leroy J. Webster		ADDRESS Princess Anne MD	
24a. REC'D BY REGISTRAR DATE JUL 31 1967		24b. REGISTRAR'S SIGNATURE	

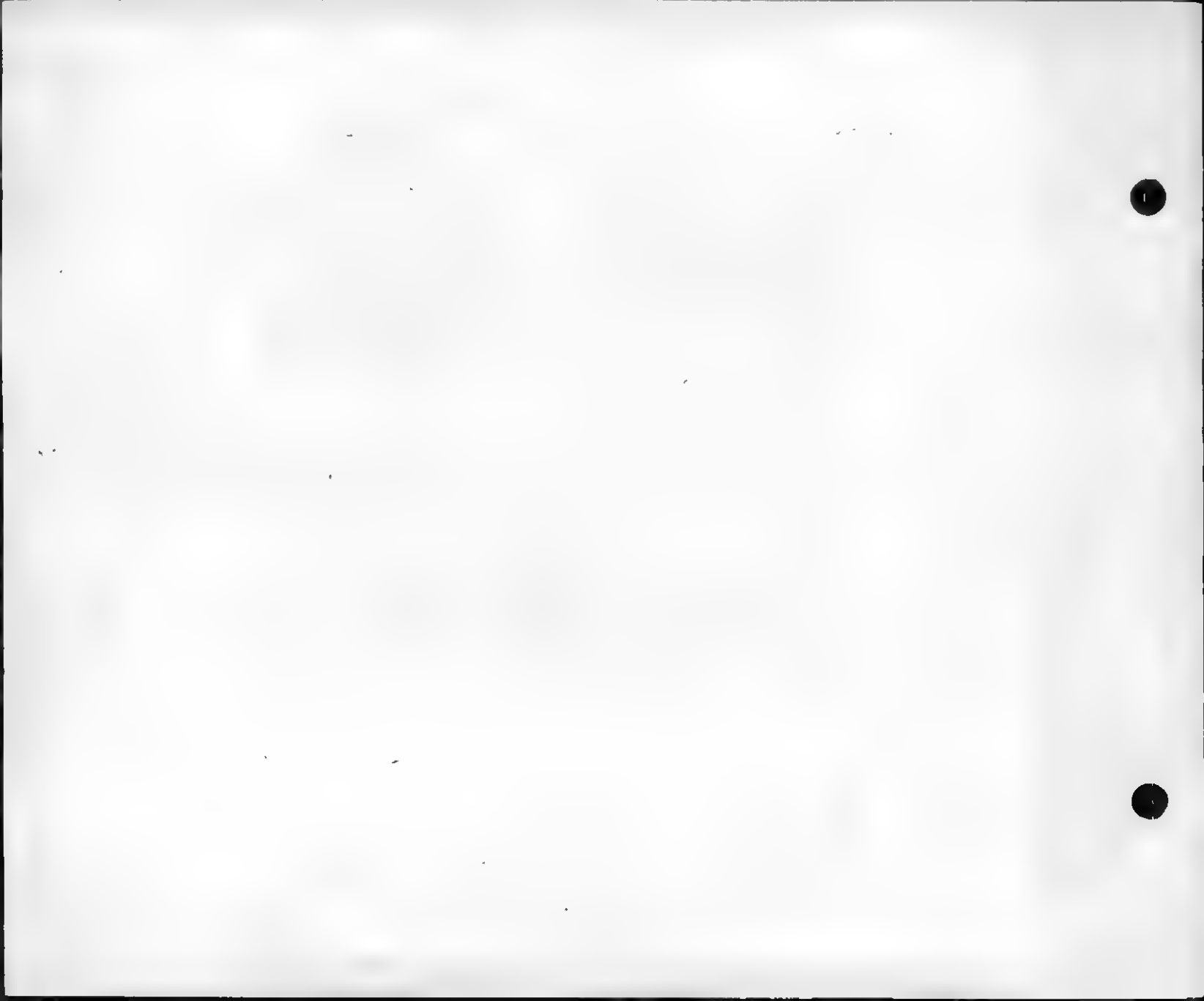
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VR A15ME (5)  
6M 1/67

Item 18 Film 390 7-21-67														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
10336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10325														
1 PLACE OF DEATH a. COUNTY WOR MARYLAND					2 USUAL RESIDENCE (Where deceased lived if inst. to or. Residence before adm. ssion) a. STATE Md b. COUNTY WOR									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN			c. LENGTH OF STAY IN Ib 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. t. give street address) Branch & Showell St					e. STREET ADDRESS Branch & Showell St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3 NAME OF DECEASED (Type or print) First Middle Last EMMA Purnell Tingle					4 DATE OF DEATH Month Day Year July 1 1967									
5 SEX F		6 COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1880		9. AGE (In years, months, days) 86 yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. PLACE (State or foreign country) Berlin, Md			12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME John James Purnell					14. MOTHER'S MAIDEN NAME Emma Line Purnell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO 217-54-5251					17. INFORMANT Address YANCIE Mumford, nephew, Berlin, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 70.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombosis, anterior mesenteric artery (c) INTERVAL BETWEEN ONSET AND DEATH Estimate 12-24 hours														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)									
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE F. S. Townsend, Jr. EXAMINER'S NAME Type, F. S. Townsend, Jr. Ocean City, Md					22. DATE SIGNED July 1, 1967									
23a. BURIAL CREMATION, REMOVAL, SPECIFY BURIAL			23b. DATE THEREOF 7-6-67		23c. NAME OF CEMETERY OR CREMATORY New Bethel			23d. LOCATION (City or Town) (County) (State) Berlin Wore. Md.						
24. F. VITAL DIRECTOR Loretta B. Jolley - Jolley Rd. #42, Salisbury, Md					25a. REC'D BY REGISTRAR JUL 7 1967		25b. REGISTRAR SIGNATURE Charles J. Jolley							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

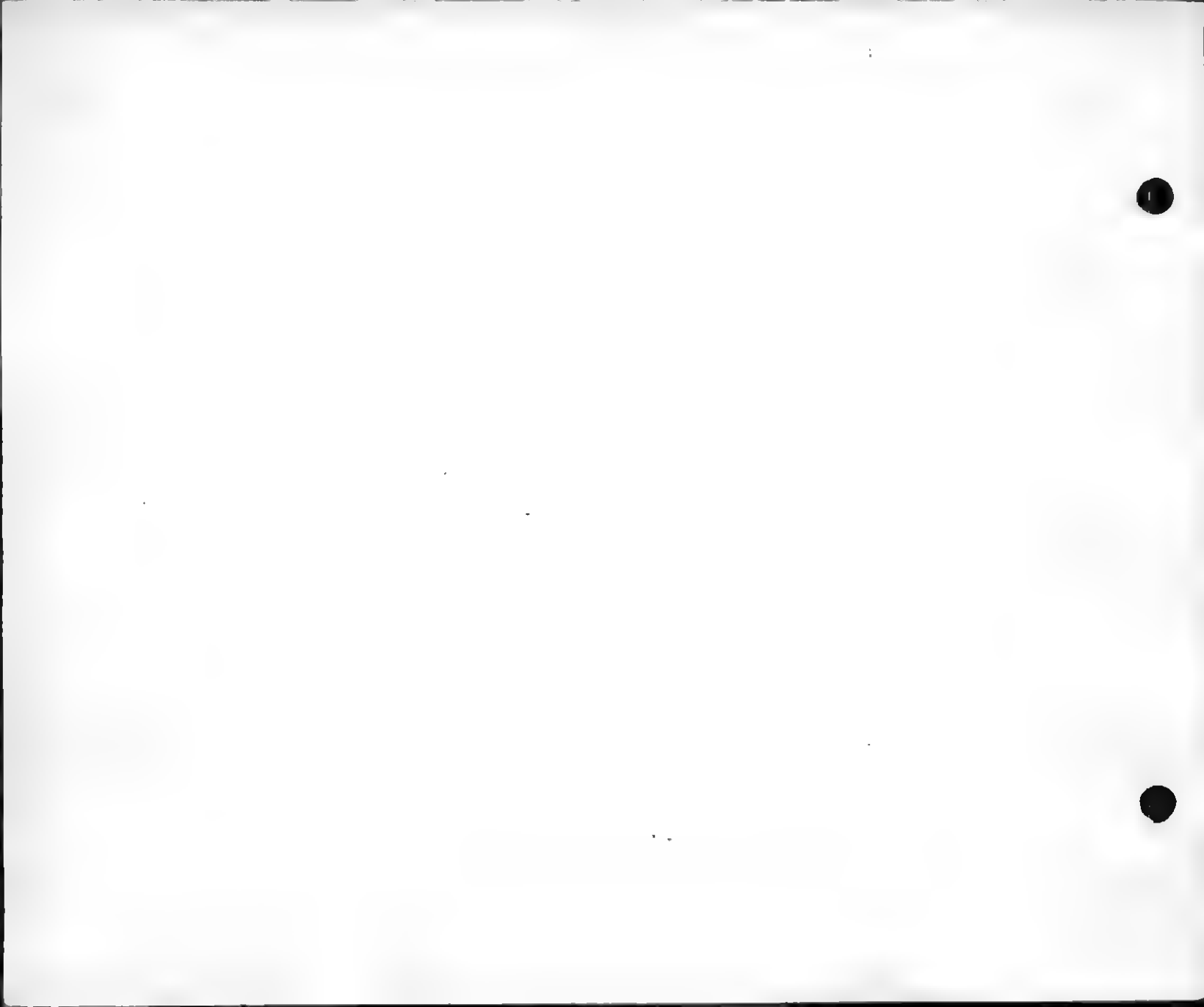
10337

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> b COUNTY <u>WOR</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c LENGTH OF STAY IN 1b <u>1 day</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>City Jail</u>		d STREET ADDRESS <u>Route 2</u>	
3 NAME OF DECEASED (Type or print) <u>Aldon F. Townsend</u>		4 DATE OF DEATH <u>July 22 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/1/20</u>
9 AGE (In years last birthday) <u>47</u> yrs		10 FLUNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		12 KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
13 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		14 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15 FATHER'S NAME <u>Frederick T. Townsend</u>		16 MOTHER'S MAIDEN NAME <u>Agnes Bradford</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		18 SOCIAL SECURITY NO. <u>216-14-9908</u>	
19 INFORMANT <u>Berlin Police Dept Record.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SUFFOCATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>HANGING (self inflicted)</u> (b) <u>MINUTES</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ethylism - Acute</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Hanged self in cell with own Belt.</u>	
20c TIME OF INJURY Month, Day, Year <u>July 22 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>City Jail</u>		20f (City or town) <u>Berlin</u> (County) <u>WOR</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend Jr.</u>		22. DATE SIGNED <u>July 22 1967</u>	
EXAMINER'S NAME (Type) <u>F. J. Townsend Jr.</u>		Address <u>Berlin City, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/26/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Riverside</u>	23d LOCATION (City or town) <u>Berlin</u> (County) <u>WOR</u> (State) <u>MD</u>
24 FUNERAL DIRECTOR <u>Anna A. Barbours</u>		ADDRESS <u>Berlin, Md</u>	
25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 2 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10338

CERTIFICATE OF DEATH

10337

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>123 2ND ST.</u>	
3. NAME OF DECEASED (Type or print) <u>MERVIN Columbus WRIGHT SR.</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1907</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CHANCE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>GEORGE WRIGHT SR.</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE BIVENS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-06-8850</u>	
17. INFORMANT <u>EDNA WRIGHT</u>		Address <u>SALISBURY, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary</u> DUE TO (b) <u>Chro Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>67</u> , to <u>7-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>8:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Chas R. Law</u>		22b. DATE SIGNED <u>7-31-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Berlin Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McCalvary</u>	23d. LOCATION (City or Town) (County) (State) <u>Fruitland Wicomico MD</u>
24. FUNERAL DIRECTOR <u>Hilda L West</u>		25a. REC'D BY REGISTRAR <u>Aug 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

88902

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10339

CERTIFICATE OF DEATH

10338

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b> c. LENGTH OF STAY IN 1b <b>29 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>902 Cedar Street</b>		d. STREET ADDRESS <b>902 Cedar Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>YOUNG</b>		4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1878</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Larimore</b>		14. MOTHER'S MAIDEN NAME <b>Martha Simmons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Edward W. Young, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Coronary Arteriosclerosis &amp; Atherosclerosis</b> DUE TO (c) <b>and Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. INTERVAL BETWEEN ONSET AND DEATH <b>few min.</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of Vagina</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>49</b> to <b>May 15</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>May 15</b> , 19 <b>67</b> , and that death occurred at <b>7 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>N.E. Sartorius, Jr.</b>		22b. DATE SIGNED <b>July 19, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>N.E. Sartorius, Jr., M.D.</b>		22d. ADDRESS <b>114 Market St., Pocomoke City, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7-20-1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke - Worcester-Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		DATE <b>JUL 24 1967</b>	

10033

*Handwritten signature*